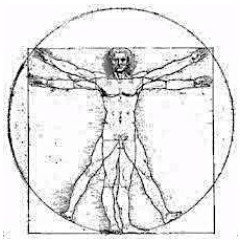


PARAGON Physical Therapy, PC
250 Executive Drive – Unit X
Edgewood, NY 11717
(Phone) 631-242-9200 | (Fax) 631-242-9202

WELCOME TO PARAGON Physical Therapy. Who can we thank for referring you?

We appreciate you choosing PARAGON Physical Therapy, PC to be your provider of physical therapy services. If you would not mind, please indicate below how you found out about our clinic. Your cooperation with this survey assists PARAGON to better anticipate present and future patient care needs.

Patient Name: _____ Evaluation Date: _____

I was referred to PARAGON Physical Therapy by (please mark an "X" next to the statement below that best describes you):

_____ I am a **returning patient** who was treated previously at PARAGON.

_____ My **primary care provider** referred me to PARAGON.

Please print full name of PCP: _____

_____ I was referred by a **specialist provider** (e.g., orthopedic, neurological, sports medicine, no fault, workers compensation)

Please print full name of specialist provider: _____

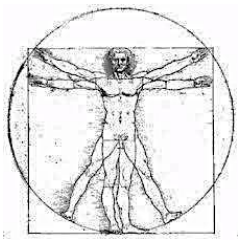
_____ I was referred by a **family member or friend**.

Please print full name of family member or friend: _____

And family relation if applicable: _____

_____ I found PARAGON on the **Internet**.

_____ Other: Please describe _____



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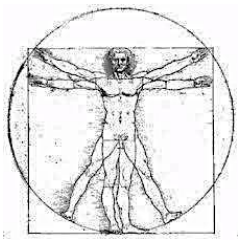
PATIENT INFORMATION		**EMAIL ADDRESS:**
First Name:	Last Name:	Date: / /
Address:	City:	State: Zip:
Birthdate: / /	Age: ☐ Male ☐ Female	Spouse's Name:
Home Phone: ( ) -	Cell Phone: ( ) -	Alt Phone: ( ) -
Please let us know who referred you to us: ☐MD ☐Family ☐Friend ☐Former Patient ☐Website ☐Other:		
Name of Person who Referred You:		
WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext:
Occupation:	Status: ☐Full Time ☐Part-Time ☐Self ☐Retired ☐Not Employed	
CARE PROVIDER INFORMATION		
Referring MD:	Referring MD Phone # : ( ) -	
Primary Care MD:	Primary MD Phone #: ( ) -	
INSURANCE INFORMATION		
Primary Insurance:		
Subscriber Name (if different):		Date of Birth: / /
ID#:	Group/Policy #:	
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		
Secondary Insurance:		
Subscriber Name (if different):		Date of Birth: / /
ID#:	Group/Policy #:	
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:		
NO-FAULT OR WORKERS COMPENSATION INFORMATION		
Insurance Name: ☐ Auto:	☐ Work:	
Adjustor/Claim Manager:	Phone: ( ) -	Ext:
Address:	City:	State: Zip:
Claim #:	WCB #:	Accident Date: / /
ATTORNEY INFORMATION		
Name:	Law Firm:	Phone #:( ) - Ext:
Address:	City:	State: Zip:
IN CASE OF EMERGENCY		
Name of Emergency Contact:		
Relationship to Patient:	Home/Cell Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to PARAGON Physical Therapy. I understand that I am financially responsible for any balance. I also authorize PARAGON Physical Therapy to release any information to process my claims.

PATIENT/GUARDIAN SIGNATURE DATE



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PAST MEDICAL HISTORY FORM

Patient Name:_____ E-Mail: _____

BLOOD PRESSURE	Yes	No
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	Yes	No
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker?	☐	☐

MUSCLE CONDITIONS	Yes	No
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back Pain	☐	☐
Neck Pain	☐	☐
Limited Limb Movements	☐	☐

LUNGS	Yes	No
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

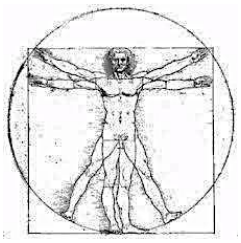
JOINT CONDITIONS	Yes	No
Upper Extremity	☐	☐
Lower Extremity	☐	☐

OTHER CONDITIONS	Yes	No
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting/Syncope	☐	☐
Polio	☐	☐
Lyme's Disease	☐	☐

Other: _____
_____
_____
_____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐None	☐Sitting	☐Low	☐Smoking	Packs a Day_____
☐1-2x/week	☐Standing	☐Medium	☐Alcohol	Drinks a Week_____
☐3-4x/week	☐Light Labor	☐High	☐Caffeine	Cups a Week_____
☐5+x/week	☐Heavy Labor			

Are you taking any seizure medications? ☐Yes ☐No If yes please list_____
Are you taking any medications that might affect your heart, lungs, consciousness or general well-being while participating in therapy?
☐Yes ☐No If yes please list_____
List all surgeries (including dates)_____
Are you pregnant? ☐Yes ☐No Current week:_____
Have you ever had any injuries related to work? ☐Yes ☐No If yes please list body part and date of injury_____
_____
Have you had any Auto Accidents? ☐Yes ☐No If yes please list body part and date of injury_____
_____
Have you ever had Physical Therapy or Massage Therapy before? ☐Yes ☐No Where?_____



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MEDICATION RECORD

List prescriptions, over-the-counter drugs, vitamins and herbal medicines.

Patient name:_____ Date:_____ Pharmacy name:_____ Phone:_____

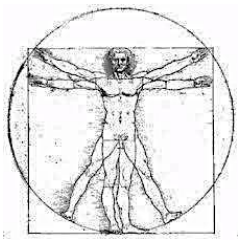
Primary doctor name:_____ Phone:_____

Medication/Dose	What is medication for?	Frequency Taken	Route of Administration

Allergies_____

Other_____

_____ _____
Signature of Patient, Parent, Guardian, Personal Representative Date



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ASSIGNMENT OF BENEFITS

Dear Patient:

As a patient of PARAGON Physical Therapy, PC we are able to accept your insurance for services rendered. We will submit a claim for your therapy procedures to your insurance company. While we are happy to provide this billing service to our patients, we do need your cooperation. By signing the Assignment and Release section below you are authorizing your insurance company to send their payment directly to us instead of yourself. **Should an insurance company send a reimbursement check directly to you for services rendered here, you agree to send that check as payment to us immediately after endorsing the back of the check as follows:**

ENDORSEMENT:
Pay to the order of:
PARAGON Physical Therapy

MAIL CHECK TO:
PARAGON Physical Therapy, PC
250 Executive Drive – Unit X
Edgewood, NY 11717

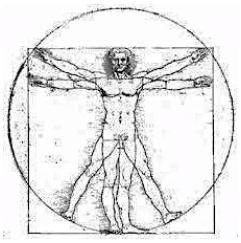
ASSIGNMENT and RELEASE: I Hereby Assign and Authorize all rights, privileges and remedies to payment of medical benefits to Cheryl Christie MS, PT, AT,C and PARAGON Physical Therapy, PC for services rendered by a licensed physical therapist or physical therapist assistant employed by Cheryl Christie, MS PT AT,C. to which I am entitled under insurance law. I understand that I am financially responsible for any balance not covered by my insurance. Notwithstanding any prior written agreement to the contrary, this agreement may be revoked by Cheryl Christie MS, PT, AT,C when payments are not payable based on the assignor's (patient) lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor (patient). I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request all authorized benefit payments be made on my behalf.

I hereby acknowledge that Cheryl Christie MS PT AT,C. will add a three (3)% charge on all past due balances, as well as the cost of any collections.

PLEASE NOTE: IF YOU DO NOT HAVE A PRESCRIPTION FROM YOUR PHYSICIAN, PODIATRIST, NURSE PRACTICIONER, OR DENTIST, OR IF YOU HAVE BEEN RECEIVING HOMECARE, YOUR PHYSICAL THERAPY VISITS MAY NOT BE COVERED BY INSURANCE.

Patient Signature_____ Date_____

Parent/Guardian Signature_____ Date_____ (If applicable)



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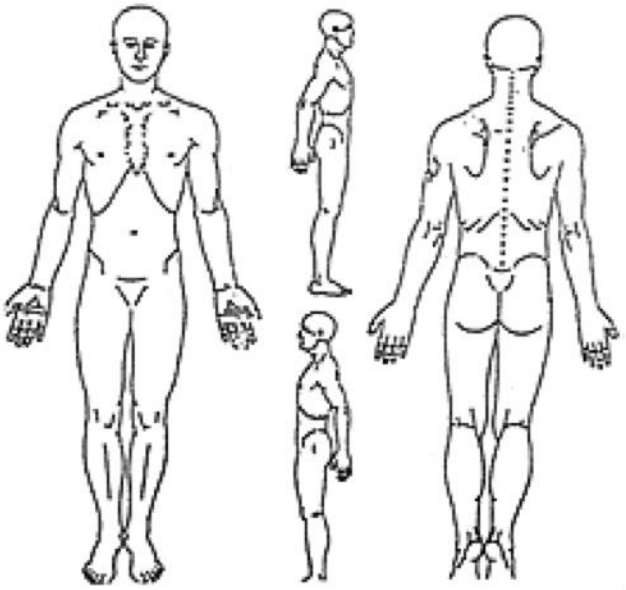
PAIN & SYMPTOMS STATUS REPORT

Patient Name:_____ Date:_____

Using the symbols below please draw on the body diagram to indicate the location and type of pain you are having.

ACHY PAIN	M M M M
BURNING	X X X X
NUMBNESS	O O O O
RADIATING PAIN	> > > > >
PINS & NEEDLES	# # # # # #
SHARP PAIN	+ + + + +
STABBING PAIN	/ / / / / / /



My primary complaint is:_____ The symptoms associated with my primary complaint began on:_____

My secondary complaint is:_____
The symptoms associated with my secondary complaint began on:_____

Please circle on the scale below to indicate your CURRENT level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets

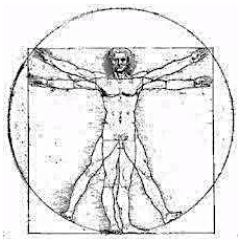
Please circle on the scale below to indicate your AVERGE level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets

Please circle on the scale below to indicate your WORST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets

What are the goals you expect to achieve by the end of Physical Therapy?_____
_____



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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as PARAGON Physical Therapy, PC or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

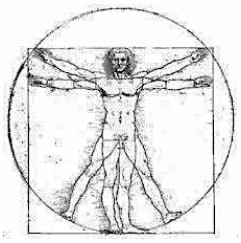
I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

_____ Name of Patient (Print Clearly)

_____ Signature of Patient Date

_____ Signature of Patient Representative

_____ Relationship of Patient Representative to Patient



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FINANCIAL POLICY

While you are here are PARAGON Physical Therapy, PC, a few rules of the road:

Assignment of Benefits: PARAGON Physical Therapy, PC will process all claims for payment. Therefore, we require you to sign an ASSIGNMENT OF BENEFITS form, which we will keep on file.

If you wish to handle the claims process personally, the treatment fee must be paid at the time of service.

Referral and Precertification: Please be sure to know your insurance coverage and copayments before your treatment starts. If your insurance requires a referral or precertification by your primary care physician, be sure to bring it in with you. If subsequent referrals are required, you will be responsible to hand them in when they are due.

If you missed authorized visits, you will not be able to make them up.

Co-payments: Your co-payment is due at the beginning of each treatment. You may pay by cash or check. Co-payments cannot be reduced or waived.

Your financial responsibility is any portion of your deductible that has not been satisfied, and any dates of treatment not covered by your insurance. If you have any questions regarding coverage we urge you to call your insurance carrier.

_____ _____

Patient Signature & Acknowledgement Date